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American Indian Issues

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Introduction

The Indian Health Service (IHS) is a federal agency primarily responsible for the delivery of health care services to American Indian and Alaska Natives. The foundation of the federal government's responsibility for meeting the health needs of American Indians and Alaska Natives is found in two major pieces of legislation: The Synder Act of 1921 and the Indian Health Care Improvement Act, Public Law 94-437, of 1976. The Aberdeen Area IHS is the principal federal health care provider for approximately 104,000 American Indians residing in the four-state area including South Dakota, North Dakota, Iowa and Nebraska. Care is provided through a network of federal and tribally managed health facilities. Four IHS hospitals, five IHS health centers and several tribal and Indian contracted health facilities and urban programs serve eight reservation-based tribes and a large contingency of urban-based Indians.

History

Federally recognized Indian tribes enjoy a government-to-government relationship with the United States. This unique relationship has been given substance through numerous treaties, Supreme Court decisions, legislation and Executive Orders.

Treaties committing the Federal government to provide medical care to Indians began toward the end of the 18th century. The United States provided the services of a physician as partial payment for rights and properties, ceded to the government. Although the treaty and most subsequent ones limited the duration of services, the Federal government adopted a policy continuing limited care after the original benefit period expired. Military doctors provided care until 1849, when the Bureau of Indian Affairs was transferred from the War Department to the newly created Department of Interior.[1] In 1955, the responsibility for Indian health was transferred to the U.S. Public Health Service.

The principal legislation authorizing federal funds for health services to recognized tribe is the Synder Act of 1921. It authorized funds "...for the relief of distress and conservation of health...{and} the employment of physicians...for Indian tribes throughout the United States." It provides for the use of "such monies as Congress may from time to time appropriate, for the benefit, care, and assistance of Indians." This language established a discretionary program, not entitlement to specific services.[2]

Policy changes since the 1970s have led to an emphasis on self-determination that did not exist during the 1950s and 1960s. Congress passed the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended) to provide tribes the option of assuming from the IHS the administration and operation of health services and programs in their communities, or to remain within the IHS administered direct health system. Congress consequently passed

the Indian Health Care Improvement Act (Public Law 94-437). This is a health-specific law that supports the options of Public Law 93-638. The goal of Public Law 94-437 is to provide the quantity and quality of health services necessary to elevate the health status of American Indians and Alaska Natives to the highest possible level and to encourage the maximum participation of tribes in the planning and management of those services.[2]

Indian Health Care

Personal care and public health services to American Indians and Alaska Native people are provided directly by the IHS, tribally contracted and operated health programs and services purchased from private providers. Services are provided through reservation and urban based programs. Currently two hundred thirty-six federally recognized tribes have contracted under Title III of Public Law 93-638 to operate their health program. This represents 43% of the federally recognized tribes in the United States. The trend for tribes to contract for program operations has increased in recent years and continues to increase.[3]

The IHS is an U.S. Public Health Service (PHS) agency within the Department of Health and Human Services. The mission of the IHS in partnership with American Indians and Alaska Natives is to raise their physical, mental, social and spiritual health to the highest level. The goal of IHS is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to all American Indian and Alaska Native people.[4]

The administration of IHS is decentralized, with 12 Area Offices responsible for operating IHS programs within designated geographic areas. The operations of the IHS health services delivery system is managed through local administrative units called service units. A service unit is the basic health organization for a geographic area served by the IHS program just as a county or city health department is the basic health organization in a State health department. Each service unit has a health facility, hospital or health center, as the focal point for the provision of health care. IHS-wide the system consists of 36 hospitals, 60 health centers, 46 health centers and 3 school health centers. In addition, 34 urban Indian health projects provide a variety of health and referral services. The IHS clinical staff consists of approximately 835 physicians, 352 dentists, 92 physician assistants and 2,594 nurses. The IHS also employs allied professionals such as nutritionists, health administrators, engineers and medical record administrators.[5]

Aberdeen Area Service Population and Area

The Aberdeen Area Indian Health Service (AAIHS) provides health services to 104,443 Indian people who reside within 13 service units. The majority resides in rural areas. Approximately 66,423 in South Dakota, 28,075 in North Dakota, 7,472 in Nebraska, 2,282 in Iowa and 191 in extreme western Minnesota. There are 16 reservations in the five-state area: 8 in South Dakota, 4 in North Dakota, 3 in Nebraska and 1 in Iowa. There are three non-reservation service areas: Rapid City, South Dakota urban Indian community; Trenton Service Area, North Dakota; and Northern Ponca Service Area, Nebraska. Seventeen tribes reside within the Aberdeen Area. Of this number, nine tribes are located in South Dakota. South Dakota represents the largest Indian population in the Aberdeen Area at 50,600. This makes up about eight percent of the South Dakota population.[5] The Area also provides health services to 3,700 Indian people who are not counted in the user population of the Area. This population does not reside within any service unit; however, they meet the eligibility criteria for health service provided at an IHS or tribally operated facility. The largest concentrations of non-service unit

eligible are found in Aberdeen and Sioux Falls, South Dakota and Bismarck and Grand Forks, North Dakota.[5]

The family is the most fundamental unit within the context of the Indian community. Data suggests the typical Indian family tends to be larger than for most other ethnic groups and substantially larger that the norm for the population as a whole. Data from the 1990 Census indicates the number of individuals per family was 4.24 for the Aberdeen Area compared to 3.16 for U.S. All Races. Important demographic features of the Indian family were the presence of children under the age of 18 and the number of two-parent families.[6]

Based on the 1990 Census, the median age for Indian residents of the Aberdeen Area was 18.8 years. The population of the Area is extremely young with 40.5% of the residents under the age of 15 while only 4.9% were over 65.[6] Although the number of Indian elders compared to the total Indian population is relatively smaller than other population groups, the number is growing.

In 1998, the birth rate for the American Indians in South Dakota was 33.9 per 1,000 population. This compares to 13.1 for White Race.[7] In 1998, South Dakota's birth rate was 14.8 per 1,000 population, while Shannon County located in the Pine Ridge Reservation was 35.8 for the same reporting period.[8]

Poverty is an issue for South Dakota tribes. Median Household Income in 1989 for the Aberdeen Area was $12,310. This is the lowest for All IHS Areas, which is $19,865. It is almost 2.5 times lower than the U.S. All Races. According to county data from the 1990 Census, eight of the poorest counties in the U.S. are located in South Dakota. Shannon County, part of the Pine Ridge Reservation, ranks as the poorest county in the U.S. Six reservations have a county ranked in the top 100 poorest counties. This is evident with almost 50% of the Aberdeen Area Indian people being below the poverty level.[5]

Like economic status, labor force participation is another indicator that can provide insight with respect to the standard of living and overall quality of life. In 1990, 26.5% of Indian males, age 16 years and older, in the Aberdeen Area were unemployed. For females, 19.4% of were unemployed.[5]

Although the quality of education for the Indian population is increasing, American Indians still lag behind the rest of the population in terms of academic achievement. Dropout rates are high and the percentage of students attending and finishing college is below other groups. According to 1990 Census, 64.4% of American Indians 25 years and older residing in the Aberdeen Area are high school graduates or higher and 7.8% have a bachelor's degree or higher as compared to 75.2% and 20.3%, respectively, for the U.S. All Races.[5]

In general, the Indian population experiences some of the worst problems related to living conditions of all populations in the U. S. Within Indian country housing statistics compare poorly with those of non-Indians. The median number of rooms per Indian household is 4.4. The median number of persons per Indian unit was 3.65 compared to 2.74 for non-Indians. According to the 1990 Census, 7.6% of the housing lacked complete plumbing facilities. Forty-seven percent of the housing units have no telephone, and 23.8% do not have a vehicle available.[9]

Health Status

The overall health status of American Indians and Alaska Natives in the United States has improved dramatically since the middle 1950s. However, the mortality and morbidity in this population remains markedly different for that of other populations. Indian life expectancy has shown dramatic increases since the early 1970s. Indian life expectancy at birth has increased

from 63.5 years to 71.1years. This is 4.4 years less than the U.S. All Races life expectancy of 75.5 for 1993 and 5.2 years less than that of the U.S. Whites.[10] The health status of American Indian is, on the whole, considerably poorer than the health of the general U.S. population. Specific problems and trends vary among the different Native populations. Irrespective o f the measurement, the health of Indian people in the Aberdeen Area is among the poorest of any group.

The Age Adjusted Mortality rate for all causes 1992-94 in the Aberdeen Area (1,055.6/100,000) is the highest within the Indian Health Service during 1993. This mortality rate is over two times the U.S. All Races population. Among the service units in South Dakota, rates ranged from a high of 1426.2 at Standing Rock to 853.3 at Rapid City.[11]

The Disease Specific Age Adjusted Mortality for the 10 leading causes of death in descending order are as follows: Diseases of Heart, Malignant Neoplasm, Unintentional Injuries, Chronic Liver Disease/Cirrhosis, Diabetes Mellitus, Cerbrovascular, Disease, Pneumonia and Influenza, Suicide, Chronic Obstructive Pulmonary Disease, and Homicide. All 10 leading causes of death in the Aberdeen Area have age adjusted mortality rates higher that those of the General U.S. population. The most alarming comparison of rates is due to chronic liver disease and cirrhosis. The Aberdeen Area rate is 12 times that of the U.S. All Races. Diabetes mellitus and unintentional injuries are four times more likely to occur among the Indian people in Aberdeen Area than the U.S. All Races population.[11]

The Aberdeen Area continues to lead the IHS in infant mortality rates. For every 1,000 live births, 15 infants will die before their first birthday. This rate is almost twice the infant death rate that occurs in the General U.S. population. Among the service units in South Dakota, rates range from a high of 25.3 at Crow Creek to 5.0 at Rapid City. The neonatal death rate for the Aberdeen Area was 7.1 per 1,000 live births. This rate is greater than All IHS Areas and U.S. All Races. Likewise, the post neonatal mortality rate was higher than the All IHS Area and U.S. All Races. Aberdeen Areas rate was 8.5 as compared to 5.8 and 3.1 for All IHS and U.S. All Races respectively. Leading causes of infant death were Sudden Infant Death Syndrome, Congenital Anomalies, Pneumonia and Influenza, Accidents and Adverse Reactions and Newborn Affected by Complications of Placenta, etc.[11]

For the Aberdeen Area, where over half of the population is under the age of 20, Years of Potential Life Lost (YPLL) is a useful indicator of health status. Indian people in the Aberdeen Area die at a younger age. Mortality data for 1992-1994 indicates 30.2% of deaths in this time frame were individuals under 45 years of age as compared to 10.7% for U.S All Races in 1993. For the same time periods, the percent of deaths among Indian people 65 years and older was 41.7 % compared to 73.0% for U.S. All Races. YPLL for the Aberdeen Area is nearly three times high than U.S. All Races. For every 100 Indians residing in the Aberdeen Area, 13 years of life are lost from All Causes of Death. The five leading causes of death that contribute to premature death are unintentional injuries, alcoholism, diseases of the heart, chronic liver disease and cirrhosis and suicide.[12]

It is well established that Indians in the Aberdeen Area and in South Dakota experience communicable and chronic diseases, injury and disabilities at higher rates as compared to their non-Indian counterparts. In 1999, 21 cases of tuberculosis (TB) were reported in South Dakota. Of this number 14 (66%) were American Indians. The TB incidence rate for American Indians was approximately nine times higher than South Dakota All Races.[13] Although the American Indian population in South Dakota represents 8% of the state's total population, American Indians represent a disproportionate higher number of notifiable communicable diseases.[7]

American Indians have the highest prevalence of diabetes of any minority group in the United States. Data from the Strong Heart Study suggests the prevalence rate of 33% for individuals 45-74 years in the Dakotas.[14] This has devastating implications for their health status. Two specific complications most prevalent among the tribes are End-Stage Renal Disease (ESRD) and Lower Extremity Amputation (LEA). Among Sioux Indians, the age adjusted incidence rate for ESRD was 4.8 times the American Indian/Alaska Native rate and 13.4 times the rate of the US. Whites. Also among the Sioux, the age adjusted incidence rate for LEA (86.7/10,000 diabetic population) was 5.5 times higher than the general population U.S. All Races rate.[15] Cardiovascular disease (CVD) is the leading cause of death among American Indians in the Aberdeen Area. The Strong Heart Study has been examining CVD in American Indians since 1989. There appears to be a rising tide of CVD among American Indian communities that is reaching epidemic proportion.[15] This trend is associated with increase in the frequency of cardiovascular risk factors, with disturbing implications for the future rates of coronary artery, cerebrovascular and peripheral vascular disease among American Indians higher than the US. Age-Adjusted Malignant Neoplasm for the Aberdeen Area is higher than the U.S. All Races. By specific disease location, Aberdeen has the highest rate for cervical cancer in the IHS and is in the top third for lung, breast, colon-rectal and prostate cancers.[16]

Unintentional and intentional injury is the leading cause of death in the 1-year to 34-year-old group in Indian country.[15] From 1985-1996, death rates for American Indians in the Aberdeen Area ages 1-19 ranked in the top three among All IHS Areas for motor vehicle crashes, pedestrian deaths, fire and burns, suicides, firearms and homicides.[17] The treatment cost of non-fatal injuries is in excess of $4.5 million annually in the Aberdeen Area.[15]

Nursing Services in the Aberdeen Area

Nursing services are an integral part of the health care delivered by the network of federal and tribal facilities serving American Indians in South Dakota. Approximately 250 nurses serve in staff, management or mid-level provider positions in a variety of settings: hospital, health center and community. The greatest number of positions are staff clinical nurses working in a hospital or health center setting. The number of public health nurses and mid-level providers are 34 and 22, respectively.[18]

Several characteristics of the nursing workforce are noteworthy. The average age of our nurse workforce is 42.2 years. Fifty-five percent of the Aberdeen Area nurse workforce is American Indian or Alaska Native. The number of Indian nurses working in the IHS continues to increase overall. This increase is taking place in all areas and care settings. Fifty-six percent of the nurses are diploma- or associate-degree prepared and less than 5% are prepared at the masters or higher degree level.[18] Thirty percent of the Indian nurses are prepared at the bachelor degree or higher. Overall, the average vacancy rate is 10%, with the greatest difficulty for filling positions in the specialty positions such as emergency room, obstetics and surgery. Generally, retention of nurses has been greatest among those Indian and non-Indian nurses that are from the reservation of employment or South Dakota in general.

Implications for Nursing Practice

While there is little doubt that the overall health status of the American Indian and Alaska Native has substantially improved in the second half of the 20th century, epidemiological data on this population detect increased areas of concern. Throughout Indian Country there is a rise in chronic diseases, especially diabetes; there is a persistence of infectious diseases and there is also

a high prevalence of multiple "social pathologies such as violence, unintentional deaths and the ill effects of alcohol and drug abuse."[19] Many of these major contributors of death and disabilities can be effectively approached through preventive health interventions. Throughout the country's health delivery system, hospital patient census and length of stay continues to decrease. Ambulatory and community based services is increasing. This trend is being seen in the Aberdeen Area. Implications of these trends are many. In the future, there will be an increased emphasis on ambulatory and community based nursing services. Nursing interventions will include activities that enhance prevention and early detection to all age groups. Nurses will need to remain current in their knowledge and skills to deal with acute situations and communicable diseases. However, nurses will be challenged to deal with an increasing number of patients with chronic diseases. The ability to case manage patients over a course of illness will become increasingly important. Providing opportunities for the patient to become competent in self-care and management of their disease will be emphasized.

The majority of Indian people in the Aberdeen Area and South Dakota are under 25 years of age. There will be a need to continue efforts to address the high rates of infant and post neonatal deaths. Adolescent and women's health programs to promote utilization of preventive services such as breast exams, mammography and cervical cancer screening will continue. Providing patients with information and support to deal appropriately with life's stressors will continue as well.

The increasing age and number of elders has implications for the type of nursing services to be provided in the future. At this time, funding levels do not permit the IHS to provide long term care. Nor is the IHS public health nursing program funded or staffed to provide or authorized to bill for home health care services. Home health and hospice care will be developed. This will be accomplished through a variety of mechanisms such as contracts and cooperative agreements. Geriatric nursing care and providing end-of-life care will become more prominent.

Characteristics of the Area's mortality and morbidity, changing demographics, and greater emphasis to ambulatory and community based services, the nursing workforce will need to be flexible to accommodate these changes. Trends such as increased use of midlevel nurse providers and increased number of Indian nurses in management positions will continue.

A rapid growth in the urban Indian population indicates a need for increased cultural understanding by all nurses. Nurses will need to confront their prejudices about Native Americans not only in providing care but also in working with Native American nurses.

Implications for Nursing Education

Although the number of number of bachelor-prepared Indian nurses is increasing, the majority is prepared at the diploma or associate degree level. Seventy percent of Indian nurses working in South Dakota facilities are prepared at the diploma or associate degree level.[18] There is a need to increase the number of nurses, especially Indian nurses, at the BSN and higher level. The delivery of high quality and effective care remains a constant challenge with the increasing complexities of health care delivery. The need for well-prepared nurse executives to provide leadership will continue. As more Indian nurses assume leadership roles, education in areas of management and administration will be essential. To address the current health disparities, nurses will be required to advance their knowledge and skills in areas such as chronic disease management, case management, behavior change, problem solving and team building.

The current nursing work force has been educated at a variety of institutions throughout the U.S and South Dakota. In South Dakota, in addition to the non reservation based Schools of

Nursing, there are three reservation based programs on the Sisseton-Wahpeton, Cheyenne River and Pine Ridge Reservations. A major portion of the current diploma or associate degree Indian nurse workforce are graduates of these programs.

There are three major IHS programs that provide financial assistance for nursing education. The IHS Scholarship Program provides preparatory and health professions scholarships. The Nurse Residency Program Section 118 provides financial assistance to achieve associate, baccalaureate and masters degrees in Nursing from programs accredited by the National League of Nursing. The IHS Loan Repayment Program provides loan reimbursement to nurses that agree to serve in a hard-to-fill area.

For the most part, reservations in South Dakota are rural which present a challenge for providing ongoing, cost-effective nursing continuing education. Access to reservation based baccalaureate and graduate programs are few. Relationships with educational programs that provide educational opportunities need to continue. In addition, innovative ways to expand baccalaureate and graduate education need to be pursued that will provide the nurse with the knowledge and skills to adapt to the changes in the health delivery system, assume positions in management and work effectively with their clients.

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